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# Benefits Counselor – April 2023

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## HEALTH PLAN DEVELOPMENTS

### Texas District Court Limits ACA Preventive Care Mandate

On March 30, 2023, the U.S. District Court for the Northern District of Texas held that portions of the Affordable Care Act's (ACA) preventive services coverage mandate are unconstitutional. Judge Reed O'Connor vacated actions taken to enforce or implement the preventive care coverage requirements related to the U.S. Preventive Services Task Force's (USPSTF) recommendations made on or after March 23, 2010. This case, *Braidwood Mgmt., Inc. v. Becerra*, follows Judge O'Connor's ruling in September 2022 that members of the USPSTF were improperly appointed under the Appointments Clause of the U.S. Constitution, as discussed in our October 2022 Benefits Counselor. The earlier decision had reserved the court's right to issue a remedy and the court requested additional briefing from the parties in that regard.

The plaintiffs in *Braidwood* sought a universal remedy that sets aside agency actions taken to implement or enforce the preventive care recommendations made by the USPSTF, which include the mandate to cover pre-exposure prophylaxis (PrEP) drugs for HIV prevention and treatment. The court agreed, finding that the Administrative Procedure Act authorized the court to vacate every action taken pursuant to the USPSTF's recommendations because the agency's members were unlawfully appointed.

The court also determined that the mandate to cover PrEP drugs was unlawful because it violated the Religious Freedom Restoration Act. According to the court, providing coverage for PrEP drugs violates the plaintiffs' religious beliefs and substantially burdens their religious exercise.

As a result of the decision, regulations and enforcement actions taken related to coverage recommendations by the USPSTF issued on or after March 23, 2010, are void effective immediately. Though not entirely clear from the decision, it appears that non-grandfathered plans must continue to cover the USPSTF's recommendations in effect prior to March 23, 2010, without cost-sharing. The reasoning is that Congress adopted USPSTF's recommendations in effect when the ACA was passed on March 23, 2010. The agencies have since issued informal guidance confirming this understanding (look for our future summary of that

guidance). Additionally, coverage recommendations from the Health Resources and Services Administration (women's preventive care recommendations, including the contraceptive coverage requirements and preventive screenings for children) and the Advisory Committee on Immunization Practices (immunizations and vaccines) of the Centers for Disease Control and Prevention are unaffected by the ruling.

The federal government has filed a notice of appeal and will likely seek a stay to allow the regulations to remain in effect during the course of the appeal.

### Agencies Issue FAQs Regarding the End of the COVID-19 Emergency Periods

On March 29, 2023, the Departments of Labor (DOL), HHS and the Treasury (collectively, the Departments) issued Frequently Asked Questions (FAQs) Part 58 regarding how the end of the COVID-19 National Emergency and public health emergency (PHE) on May 11, 2023, affect COVID-19 coverage and payment requirements under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

The FAQs confirm that plans are not required to provide coverage for COVID-19 tests, services and related items furnished after the end of the PHE. For COVID-19 testing services, plans should use the first date on which a service was rendered to determine if the service was "furnished" during the PHE. Although not required, the FAQs emphasize that plans are encouraged to continue to cover COVID-19 benefits at no cost.

The FAQs reference prior guidance the Departments provided related to notices and clarify that a notification furnished for a prior plan year will not satisfy the obligation to provide advance notice for changes in coverage in the current plan year.

As noted in the FAQs, the statutory requirements under section 3203 of the CARES Act continue to apply after the end of the PHE. Accordingly, non-grandfathered plans must continue to cover, without cost sharing, qualifying coronavirus preventive services, including COVID-19 vaccines, when provided in-network. Note that this obligation is not impacted by the *Braidwood Mgmt., Inc. v. Becerra* case discussed above.

The FAQs provide that the special rule allowing for coverage of COVID-19 testing and treatment before satisfaction of the deductible for individuals covered by a high deductible health plan (HDHP) remains in effect. The FAQs clarify that the prior guidance (Notice 2020-15) does not sunset with the end of the PHE, and

relief will continue to be provided until further guidance is issued. Accordingly, HDHPs may continue providing coverage for COVID-19 testing and treatment before the deductible is satisfied, and covered individuals will remain eligible to participate in a Health Savings Account (HSA).

The FAQs note that the Outbreak Period is expected to end on July 10, 2023 (60 days after the anticipated end of the COVID-19 National Emergency). As of the last day of the Outbreak Period, the extensions under the emergency relief notices for timeframes that began during the COVID-19 National Emergency no longer apply. The FAQs include examples of how these rules work, assuming the Outbreak Period will end on July 10, 2023. The Departments appear to recognize the possibility that President Biden may end the COVID-19 National Emergency earlier, reiterating the original guidance that the Outbreak Period will end 60 days after the end of the National Emergency or such other date identified by the Departments in a subsequent notice. In any event, the FAQs encourage group health plans to continue to allow longer plan deadlines.

### Agencies Issue Revised Guidance Regarding Surprise Billing IDR Process

The DOL, HHS and Internal Revenue Service (IRS) recently issued revised guidance regarding the independent dispute resolution (IDR) process for disputing parties (e.g., plans, insurers and providers) and certified IDR entities.

The agencies revised the IDR process guidance documents to reflect the court's recent decision in *Texas Medical Association v. HHS*. As discussed in our March 2023 Benefits Counselor, this decision vacated the regulations implementing the surprise billing IDR provisions of the No Surprises Act that addressed the information a certified IDR entity may consider in determining a party's payment amount. The court found that the regulations placed an "outsized weight" on the qualified payment amount (QPA) and impermissibly limited the arbitrator's ability to exercise discretion when evaluating claims.

In response to the court's decision, the updated guidance documents instruct certified IDR entities to consider QPAs and other information to determine the payment amount. The documents eliminated the language indicating that non-QPA factors may only be considered if the additional information is credible, relates to a party's offer and is not already reflected in the QPA.

The updated guidance documents are effective for payment determinations made on or after February 6, 2023, for items and services furnished on or after October 25, 2022, and for plan years beginning on or after January 1, 2022. Prior

guidance documents updated in October 2022 continue to apply to payment determinations made before February 6, 2023, for items and services furnished by an out-of-network provider on or after October 25, 2022.

### IRS Issues FAQs on Reimbursements for Nutrition and Wellness Expenses

On March 17, 2023, in IR 2023-47, the IRS announced that it posted FAQs regarding when certain expenses related to nutrition, wellness and general health are considered medical expenses under Internal Revenue Code (Code) section 213 that may be reimbursed or paid for by a HSA, health flexible spending arrangement (FSA), Archer medical savings account (Archer MSA) or health reimbursement arrangement (HRA).

An item or service generally must qualify as "medical care" expenses under Code Section 213(d) to be deductible or subject to tax-exempt reimbursement. Medical expenses include the costs of diagnosis, cure, mitigation, treatment or prevention of disease, and for the purpose of affecting a structure or function of the body. Medical expenses must be primarily to prevent or alleviate a physical or mental defect or illness. Expenses that are merely beneficial to general health are not qualified medical expenses.

The FAQs reiterate that dental, eye and physical exams qualify as medical care expenses under Code section 213 because they provide a diagnosis of whether a disease or illness is present. The costs of substance abuse, alcohol treatment or smoking cessation programs are qualified medical expenses because these programs treat a disease. Furthermore, therapy is a qualified medical expense if it treats a disease, such as a diagnosed mental illness.

According to the FAQs, nutritional counseling qualifies as a medical expense if the counseling is for a diagnosed disease (e.g., obesity or diabetes). Similarly, weight-loss programs are qualified medical expenses when the program treats a diagnosed disease (e.g., obesity, diabetes, hypertension or heart disease).

A gym membership is a qualified medical expense only when the membership is purchased for the sole purpose of affecting a structure or function of the body (i.e., a prescribed plan for physical therapy to treat an injury) or for the sole purpose of treating a diagnosed disease (e.g., obesity, hypertension or heart disease). The cost of exercise to improve general health is not a qualified medical expense.

Food and beverages are qualified medical expenses only when (1) the food or beverage does not satisfy normal nutritional needs; (2) the food or beverage

alleviates or treats an illness; and (3) a physician substantiates the use of the item. The medical expense is limited to the amount by which the food or beverage cost exceeds that of a product that satisfies normal nutritional needs.

Besides the costs of insulin, over-the-counter drugs and medicines generally cannot be deducted as a medical expense. However, these costs (and menstrual care products) may be paid for or reimbursed by an FSA, HSA, HRA or Archer MSA.

### IRS Announces Increase in Penalties for ACA Employer Mandate

The IRS has announced the 2024 ACA employer mandate penalties for applicable large employers (ALE). ALEs are employers with 50 or more full-time and/or full-time equivalent employees. The A Penalty for an ALE's failure to offer minimum essential coverage to a sufficient number of full-time employees under Code section 4980H(a) will be $2,970, representing a $90 increase from 2023. The B Penalty for an ALE's failure to offer affordable, minimum value coverage under Code section 4980H(b) will be $4,460, representing a $140 increase from 2023.

The IRS issues 226-J letters to employers to inform them they may be liable for employer mandate penalties.

## RETIREMENT PLAN DEVELOPMENTS

### President Biden Vetoes Bill Blocking DOL Rule on ESG

On March 20, 2023, President Biden issued his first veto to block a bill that would have nullified the DOL's final rule titled "Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights." This rule, informally known as the "ESG rule," allows fiduciaries to consider climate change and additional environmental, social and governance (ESG) factors when making investment decisions. The ESG rule became effective on January 30, 2023. As a result of the veto, the ESG rule will remain in effect.

Please see our December 2022 Benefits Counselor for further discussion regarding the ESG rule.

### Seventh Circuit Revives Hughes v. Northwestern University Excessive Fee Case

The U.S. Court of Appeals for the Seventh Circuit recently issued a decision reviving the participants' allegations in *Hughes v. Northwestern University* that Northwestern University (Northwestern) breached its fiduciary duty of prudence under the Employee Retirement Income Security Act of 1974 (ERISA). As discussed in our February 2022 Benefits Counselor, the U.S. Supreme Court rejected the

Seventh Circuit's reliance on a "categorical rule" that providing some low-cost options eliminates concerns about other investment options being imprudent. The Supreme Court remanded the case and asked the Seventh Circuit to consider the appropriate pleading standard that applies to the participant's breach of fiduciary duty claims, specifically regarding the duty of prudence.

On remand, the Seventh Circuit rejected Northwestern's argument that the heightened pleading standard set forth in *Fifth Third Bancorp v. Dudenhoeffer* should apply, noting that *Dudenhoeffer* involved an employee stock ownership plan (ESOP) in which fiduciaries allegedly had inside information about the company stock.

According to the Seventh Circuit, to plead a breach of the duty of prudence. "a plaintiff must plausibly allege fiduciary decisions outside a range of reasonableness." Additionally, "[h]ow wide that range of reasonableness is will depend on 'the circumstances[...]prevailing' at the time the fiduciary acts." Finally, "[t]he discretion accorded to an ERISA fiduciary 'will necessarily be context specific.'" At the pleadings stage, a plaintiff must provide sufficient facts to show that a prudent alternative action was plausibly available, rather than actually available.

Applying the pleading standard to the remaining claims in *Hughes*, the Seventh Circuit concluded the participants sufficiently alleged that Northwestern incurred unreasonable recordkeeping fees. The court noted that participants plausibly alleged that recordkeeper consolidation and soliciting an equally capable but lower-cost recordkeeper were available options.

The participants also claimed that Northwestern offered a number of mutual funds in the form of retail share classes with higher fees than those charged by otherwise identical institutional share classes of the same investments. Regarding this claim, the Seventh Circuit ruled that the participants plausibly alleged that waivers of investment minimums were possible and that Northwestern could have negotiated for institutional-class shares.

The Seventh Circuit, however, found that the participant's final claim that the plan included too many investment options, which confused participants, was not plausible because the complaint included unspecific allegations and did not identify how the participants were confused.

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## GENERAL DEVELOPMENTS

### Eighth Circuit Rules No Requirement to Exhaust Administrative Remedies Absent Review Language in Plan Document

In *Yates v. Symetra Life Insurance Company*, the U.S. Court of Appeals for the Eighth Circuit affirmed a district court ruling that a plan participant is not required to exhaust administrative remedies before challenging a benefit denial in court when an ERISA plan's written plan documents do not mention the review process or administrative remedies to be exhausted.

A participant brought claims for benefits under her employer's ERISA life insurance and accidental death and disability (AD&D) plans after her spouse died of a heroin overdose. The plans were issued and managed by Symetra Life Insurance Company (Symetra). The relevant policies and plan language were summarized in an "Employee Benefits Insurance Certificate" issued to covered employees.

Symetra denied the participant's claim for AD&D benefits. The denial letter explained that the participant could appeal Symetra's decision by submitting a written request within 60 days and outlined the internal review process. The written plan documents, however, did not mention the internal review process or provide for any other appeal or review procedures following a denial of benefits.

Instead of using Symetra's internal review process, the participant sued. Symetra argued that the participant's failure to exhaust the internal review process described in the denial letter precluded her from bringing an ERISA suit. The district court disagreed.

On appeal, Symetra conceded that the plan documents did not contain internal review procedures; however, the insurer argued that the participant's claim was barred because she failed to exhaust the administrative remedies described in the denial letter. The Eighth Circuit rejected Symetra's argument, noting that the requirement to exhaust administrative remedies is consistently premised on those remedies being expressly prescribed in the written plan documents. According to the court, requiring a participant to exhaust internal review procedures that cannot be found in the plan documents would render reliance on those documents largely meaningless.

This case serves as a reminder that the claims procedures must be included in the formal plan document or expressly incorporated by reference. These procedures must also be set forth in the plan's summary plan description. If these

requirements are not met, a participant may be able to sue without exhausting the plan's internal review process.

## UPCOMING COMPLIANCE DEADLINES AND REMINDERS

### Retirement Plan Deadlines

Annual Funding Notice. Calendar year-defined benefit plans with over 100 participants must provide the Annual Funding Notice by April 30, 2023.

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Reinhart's Employee Benefits Practice is one of the largest and most tenured in the country:

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